Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **NVS6021PCS**	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C **07/15/2013**

NAME OF PROVIDER OR SUPPLIER **ALL VALLEY HOME HEALTH CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1840 E CALVADA UNIT 9** **PAHRUMP, NV 89048**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility from 7/15/13 and finalized on 7/30/13, in accordance with Nevada Revised Statutes, Chapter 449,Personal Care Service Agencies. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint # 00036143 - The allegations regarding quality of care/treatment was not substantiated through document review and interview with staff. The allegation of physical environment, facility not clean was not substantiated through observation. The allegation of physical environment infection control practices not followed was not substantiated through observation and employee record review of training. The allegation of resident/patient/client abuse, employee to resident was not substantiated through record review and interview with staff.	P 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE